Current Medical History

Do you wear glasses? **Y / N** If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? **Y / N** If yes, how old is your present pair of lenses? _____

Personal & Family Medical / Eye History

Cancer:	Self / Family _____ (Relation)	Cataracts:	Self / Family _____ (Relation)
Diabetes Type 1:	Self / Family _____ (Relation)	Macular Degeneration:	Self / Family _____ (Relation)
Diabetes Type 2	Self / Family _____ (Relation)	Glaucoma:	Self / Family _____ (Relation)
High Blood Pressure:	Self / Family _____ (Relation)	Amblyopia (lazy eye):	Self / Family _____ (Relation)
Thyroid Problems:	Self / Family _____ (Relation)	Keratoconus:	Self / Family _____ (Relation)

Other *(including eye surgeries, diseases, etc.)*:

_____

_____

_____

Medications:

List of Medications & Use *(including Birth Control & Over the counter medications):*

_____

_____

_____

Do you have any allergies to Medications? *(if yes, explain):*

_____

_____

Do you have any other allergies? *(food, animal, environment, latex, etc.)*

_____

_____

Social History:

Do you smoke? **Y / N**

Do you drink alcohol? **Y / N**

Do you use a computer? **Y / N** if yes, how many hours per day: _____*hrs.*

Are you pregnant? **Y / N**

Height: ____ft. ____in. Weight: _____ lbs.